**PUBLIC HEALTH COUNCIL**

Meeting of the Public Health Council, Tuesday, June 22, 1999 at 10:00 a.m., Massachusetts Department of Public Health, Henry I. Bowditch Room, Second Floor, 250 Washington Street, Boston, Massachusetts. Present were: Dr. Howard K. Koh , Chairman, Dr. Clifford Askinazi, Mr. Manthala George, Jr., Ms. Shane Kearney Masaschi, Mr. Albert Sherman, Ms. Janet Slemenda, Mr. Joseph Sneider, and Dr. Thomas Sterne; Bert Yaffe absent. Also in attendance was Ms. Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Mass. General Laws, Chapter 30A, Section 11A 1/2. Chairman Koh acknowledged the contribution of James Phelps to the Public Health Council and welcomed new Council Member Shane Kearney Masaschi.

The following members of the staff appeared before Council to discuss and advise on matters pertaining to their particular interests: Mr. Paul Hunter, Acting Director, and Mr. Roy Petre, Assistant Director, Childhood Lead Poisoning Prevention Program; Ms. Louise Goyette, Director, Office of Emergency Medical Services; Ms. Deborah Klein-Walker, Assistant Commissioner, Bureau of Family and Community Health; Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management; Dr. Paul Dreyer, Director, Bureau of Health Care Quality; Ms. Joyce James, Director, Ms. Joan Gorga, Analyst, and Ms. Holly Phelps, Consulting Analayst, Determination of Need; Ms. Susan Etkind, R.N., Director, Division of Tuburculosis Prevention and Control; and Attorney Carl Rosenfield, Deputy General Counsel.

**REQUEST APPROVAL OF AMENDMENTS TO THE 1998 BY-LAWS OF LEMUEL SHATTUCK HOSPITAL AND PATIENT CARE ASSESSMENT PLAN:**

After consideration, upon motion made and duly seconded, it was voted (unanimously): to approve amendments to the 1998 Medical Staff By-Laws and Patient Care Assessment Plan of Lemuel Shattuck Hospital, Jamaica Plain, MA.

**PERSONNEL ACTIONS:**

In a letter dated May 25, 1999, Howard K. Koh, M.D., Commissioner, Department of Public Health, recommended approval of the appointment of Teresa Anderson to Program Manager V (Research Coordination Manager). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications upon motion made and duly seconded, it was voted (unanimously): That in accordance with the recommendation of the Commissioner of Public Health, under the authority of Massachusetts General Laws, Chapter 17, Section 6, the appointment of Teresa Anderson to Program Manager V (Research Coordination Manager) be approved.

In a letter dated May 18, 1999, Mr. John Britt, Executive Director, Massachusetts Hospital School, recommended approval of appointments to the allied health professional staff of Massachusetts Hospital School. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Massachusetts Hospital School, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments to the allied health professional staff of the Massachusetts Hospital School be approved for the year 1999-2000.

| **APPOINTMENTS:** | **SPECIALTY:** | **STAFF CATEGORY:** |
|---|---|---|
| Diana L. King, Psy.D. | Psychology | Allied Health Professional |
| Wayne L. Klein, Ph.D. | Psychology | Allied Health Professional |

In a letter dated June 14, 1999, Dr. Katherine Domoto, Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the active and consultant staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration, upon motion made and duly seconded, it was voted unanimously that, in accordance with the recommendation of the Associate Executive Director of Medicine, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the active and consultant staffs of Tewksbury Hospital be approved:

| **NAME:** | **SPECIALTY:** | **MASS. LICENSE #:** |
|---|---|---|
| Richard Shapiro, M.D. (Appointment) | Psychiatry | 77654 |
| Nicholas Casaburi, M.D. (Reappointment) | Active Psychiatry | 28122 |
| Amy Lisser, M.D. (Reappointment) | Active Psychiatry | 39537 |
| Jeffrey Simmons, M.D. (Reappointment) | Consultant Psychiatry | 39537 |

Note – Docket Item # 3b below (Request for Final Promulgation of Licensure Regulations for Universal Newborn Screening and Related Amendments to the Hospital Licensure Regulations (105 CMR 130.000) and Birth Center Licensure Regulations (105 CMR 142.000) was heard out of turn.

**REQUEST FOR FINAL PROMULGATION OF LICENSURE REGULATIONS FOR UNIVERSAL NEWBORN HEARING SCREENING AND RELATED AMENDMENTS TO THE HOSPITAL LICENSURE REGULATIONS (105 CMR 130.000) AND BIRTH CENTER LICENSURE REGULATIONS (105 CMR 142.000):**

Dr. Deborah Klein Walker, Assistant Commissioner, Bureau of Family and Community Health, introduced the Regulations to Council. She began, "…I am very excited to be here to bring you a final draft for your approval of the regulations for the universal newborn hearing screening law. In November 1998, Chapter 243 of the Acts of 1998, An Act Providing for Hearing Screening of Newborns, was signed into law. The Universal Newborn Hearing Screening Law, as the Massachusetts statute is known, mandates that a hearing screening be performed on all newborns in the Commonwealth of Massachusetts prior to discharge from a hospital or birth center. This law mandates that the Department promulgate regulations to implement universal newborn hearing screening. It is therefore necessary to amend the Hospital Licensure Regulations and Birth Center Licensure Regulations. Since January of 1999, the Department has been working with a multi-disciplinary advisory committee to develop these amendments. The amendments include requirements for screening programs, information provided to parents or guardians, and data to be submitted to the Department.

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve Final Promulgation of Licensure Regulations for Universal Newborn Hearing Screening and Related Amendments to the Hospital Licensure Regulations (105 CMR 130.000) and Birth Center Licensure Regulations (105 CMR 142.000); that a copy of the amended regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as Exhibit Number 14,653.**

**STAFF PRESENTATIONS:**

**"1998 TUBERCULOSIS STATISTICAL REPORT"**

Ms. Susan Etkind, R.N., M.S., Director, Division of Tuberculosis Prevention and Control, presented the 1998 Tuberculosis Statistical Report. She said in part, "…In 1998, we maintained our low TB case rate of 4.7 per 100,000…Although we had a slight increase in 1998, our rate represents a 34 percent decrease overall since 1992…In terms of basic demographics, Suffolk County continues to account for approximately one-third of the TB cases reported. Fourteen communities accounted for 65 percent of our cases last year. The City of Boston had the highest case rate, almost 16 per 100,000, and cases increased in the city by 14 percent last year. In addition to Boston, the other cities reporting increases included Cambridge, Lawrence, Lowell, Quincy and Somerville. However, cities reporting decreases in case rates included Brockton, Framingham, Lynn, Chelsea, Springfield, Worcester and New Bedford. This year, three cities were actually removed from our so-called higher risk city list. And these included Revere, Fall River and Waltham. Fifty-six percent of the cases in 1998 were male. And, interestingly, the gap between male and female TB cases has been narrowing since 1992. Cases in the 25 to 44 year old age group continue to represent the largest proportion of cases…Only 29 percent of the TB cases in 1998 were white/non-Hispanic. Seventy-one percent were among persons of color. Case rates for Asian/Pacific Islanders have increased from 43.2 per 100,000 in 1988 to 64.1 in 1998. Although we have achieved TB elimination among white/non-Hispanic persons in Massachusetts (this is 1.3; TB elimination being defined as 3.5 per 100,000, this is clearly not the case for other groups…Although case rates in children and teens remain low, just over 4 per 100,000 in 1998, 65 percent of cases in children were reported among persons of color. In terms of drug resistance, last year 11 percent of all bacteriologically confirmed TB cases had some form of drug resistance. This is similar to the trend in previous years…Twenty-one percent of the drug resistant cases were among white/non-Hispanics. The balance were among persons of color. Seventy-nine percent of all drug resistant cases were born outside of the United States. On the national level, four factors have been suggested to account for the earlier rise in TB. The first of these is increased immigration from high prevalence countries. TB in the developing world is a staggering problem. It is responsible for 26 percent of avoidable deaths in the developing world. An estimated 3 million people die from TB each year, 300,000 of those being children. Seven billion people, or a third of the world's population, are infected with drug resistant tuberculosis. TB accounts for a third of AIDS mortality worldwide. This is tuberculosis in the world today. Numbers of cases from some areas of the world are in the millions. There are about 20,000 in the U.S. But, for example, Southeast Asia has 3 million; China, a million; sub-Sahara Africa, 2 million cases. With the ease of travel, and the mobility of much of the world's populations, what happens in the rest of the world cannot help but affect us. The foreign-born continue to be the highest risk group for tuberculosis and account for 67 percent of all cases reported in 1998…"

Ms. Etkind continued, "The next risk group is those persons who are at risk for transmission of TB who live in congregate settings such as the homeless. Case rates in this population are estimated to be around 39 per 100,000. This is a continuing decline. Moving on to another congregate setting, correctional facilities. We continue to have very few cases reported from this setting. In 1998, only one percent of the cases were reported from such facilities…The third factor associated with the earlier rise in TB was the HIV epidemic. Relative to the TB/AIDS trend data, it can be seen that significant differences continue to exist between TB/AIDS cases. In 1998, seven cities accounted for 73 percent of the TB/AIDS cases, the highest percent from the City of Boston. The data, as presented, indicate that although there are still areas to reach in our efforts to control TB cases, particularly in terms of targeted efforts towards foreign-born populations, there are clear indicators that we are continuing to make substantial progress toward our goal of TB elimination in Massachusetts. One of the main reasons for this is that Massachusetts has maintained its public health infrastructure for TB control, the fourth factor cited nationwide in terms of factors for increases in cases…There are new things on the horizon. There are efforts for targeted testing and treatment, to try to get at the persons who are most at risk, that is contacts, persons who are HIV infected, etc.. We are trying to do away with testing that is not necessary, and trying to deal with many challenges in the private sector. So, I think we have made a lot of progress, but we have a long way to go."

**REGULATIONS:**

**REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 170.000: REGULATIONS FOR THE IMPLEMENTATION OF M.G.L. 111C, GOVERNING AMBULANCE SERVICES AND COORDINATING EMERGENCY MEDICAL CARE AND 105 CMR 700.000: IMPLEMENTATION OF M.G.L. CH. 94C:**

Ms. Louise Goyette, Director, Office of Emergency Medical Services, said in part, "… On February 23, 1999, the Public Health Council (PHC) approved emergency regulations to amend both the EMS and Drug Control regulations to enable the administration of certain controlled substances in Schedule VI by Emergency Medical Technicians (EMTs) certified at the EMT-Basic level (EMT-B), subject to provisions established by the Department. A recent change in the U.S. Department of Transportation (DOT)/National Highway Traffic Safety Administration's national standard curriculum for the initial training of EMT-Basics provides for teaching the EMT-B to administer certain medications, which have been prescribed for and are in the possession of a specific patient. These medications include auto-injectable epinephrine, nitroglycerin and a hand-held inhaler. The requested changes in the EMS and Drug Control regulations will enable EMTs who complete the revised curriculum training to provide this important, and potentially life-saving care. The Department estimates that by July 1, 1999, over 50% of all working EMT-Bs will have completed upgraded training either through initial, refresher or continuing education courses. Within two years, all EMT-Bs will have completed training consistent with the revised DOT curriculum. The Department requests PHC approval to proceed with final promulgation of the amendments to the EMS and Drug Control regulations to accomplish the following:

(1) to permit EMTs who are performing patient care duties while working for a duly registered ambulance service or first responder agency to administer those Schedule VI medications that are approved by the Department subject to the provisions of the EMS regulations;
(2) to add first responder agencies (primarily fire and police departments) as potential registrants if such agencies employ EMTs who are trained to the revised standards; and
(3) to permit EMTs to administer certain Schedule VI medications approved by the Department provided that:

- the medication administration conforms to the Emergency Medical Services Pre-Hospital Treatment Protocols approved by the Department;
- an EMT administering such medications is properly trained;
- an EMT administering such medications does so as an employee (paid or volunteer) of a duly registered ambulance service or first responder agency;
- the ambulance service or first responder agency, for which such EMT is employed, has a current memorandum of agreement with a hospital to address quality assurance; and
- first responder agencies that employ EMTs who perform such medication administration have a current agreement with a transporting ambulance service(s) to ensure continuity of patient care.

No oral or written testimony was submitted and the Department is not recommending any changes from the amendments initially presented."

After consideration, upon motion made and duly seconded, it was voted unanimously **to approve final promulgation of amendments to 105 CMR 170.0000: Regulations for the Implementation of M.G.L. 111C, Governing Ambulance Services and Coordinating Emergency Medical Care and 105 CMR 700.000: Implementation of M.G.L. Ch.94C;** that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,652**. A public hearing was held on May 24, 1999.

**PROPOSED REGULATIONS:**

**INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 130.000 (HOSPITAL LICENSURE) GOVERNING DISPOSITION OF REMAINS FOLLOWING TERMINATION OF PREGNANCY:**

Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management, said, "This is for informational purposes. There is a law on the books, Massachusetts General Laws, Chapter 111, Section 202, which has been on the books for about 20 years which deals with the disposition of remains following a fetal death. Section 202 defines fetal death as "death prior to the complete expulsion or extraction from its mother of a fetus, irrespective of the duration of a pregnancy," which is an operative sentence in this chapter. The statute primarily is intended to enumerate a number of circumstances where fetal death must be reported. Those reporting requirements, which are the bulk of this chapter, are triggered only when the fetus has a gestational age of at least 20 weeks, or weight of 350 grams or more. That is the bulk of that particular statute. Section 202, however, does go on and towards the end of the section it provides that the disposition of fetal remains shall be at the direction of the parents. It is quite explicit from that standpoint. Disposition can be burial, entombment, or cremation. Hospitals are required to inform parents of their right to either direct disposition or to allow the hospital to handle the disposition. Finally, the statute requires the parents be informed of the availability of counseling, and to be informed in writing of the hospital policy relating to the disposition of fetal remains. The proposed amendment incorporates the requirements of Section 202 into the hospital licensure regulations, and goes further in that it clarifies the requirements that the parents be given the choice of burial, entombment, cremation, or having the hospital handle the disposition regardless of the duration of the pregnancy. We have scheduled a public hearing for July 23rd in order to take public comment on the proposed regulations. We hope that this will help to clarify the process that a hospital would use in giving parents their absolute maximum amount of both counseling and information that they need to make a decision at a time where a misfortune such as a miscarriage has occurred. It is very explicit; this law does not apply to abortions in any way, shape, or form. It is solely in dealing with a miscarriage."

INFORMATIONAL ONLY

**INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO LEAD POISONING PREVENTION AND CONTROL REGULATIONS (105 CMR 460.000):**

Mr. Roy Petre, Assistant Director, accompanied by Mr. Paul Hunter, Acting Director, Childhood Lead Poisoning Prevention Program, said in part, "The principal program that these draft regulations would implement is moderate-risk abatement by unlicensed owners and their agents. This is a provision that exempts owners and their agents from the general requirement that only licensed deleaders may conduct residential lead abatement. This is a program whereby, following a day's training, and a written examination, unlicensed owners will be able to remove woodwork and windows from residential premises as long as demolition is not part of that process. The purpose here is to dramatically increase the number of residences brought into compliance with the Lead Law, and thereby provide many more children with lead safe homes. We worked a year and a half with a certified industrial hygienist to make sure that the provisions of this program would be safe from an occupational health standpoint. As we implement this program, we are dramatically tightening the principal provision that we have to ensure that deleading is carried out safely. We have a standard for a number of surfaces that requires the dust lead levels be below a certain threshold. The principal surface that presents risks to children, as established by HUD, is the floor. And that makes sense because we are talking about young children who are crawling around and exploring the world. Hand to mouth activity is the pathway through which children become poisoned. Currently, the threshold for dust lead levels on floors is 200 micrograms per square foot. We are proposing a new level of 50 micrograms per square foot. This is a level that EPA is recommending and it is going to add a very significant measure of protection as we move forward with this new program..."

Mr. Petre continued, "…One of the other major proposals in this set of regulations is codifying policies and procedures that the program has had in place for years but had never really been part of the regulatory scheme. The Lead Law does not require the removal of all lead paint. In Massachusetts, we have been

deleading homes since the 1970s…We are seeing situations where homes that were in compliance with the law no longer meet those conditions. We have codified regulations, the process whereby lead violations are determined after compliance and how they are corrected. We have incorporated a major streamlining process in our regulations. We have deleted references to provisions and requirements that appear in written policies, protocols, training materials, and other situations, other forms in the program. By deleting these from the regulations, we will be able to streamline them very significantly. This is in line with our Executive Order 384 that intends to reduce the regulatory burden."

INFORMATIONAL ONLY

**DETERMINATION OF NEED:**

**COMPLIANCE MEMORANDUM:**

**PREVIOUSLY APPROVED DON PROJECT NO. 4-1382 OF SHARON SENIOR CARE CENTER – REQUEST TO INCREASE THE GROSS SQUARE FEET, THE NUMBER OF BEDS TO BE REPLACED, AND THE MAXIMUM CAPITAL EXPENDITURE:**

Ms. Joyce James, Director, Determination of Need Program, said, "Sharon Senior Care Center has submitted a request for a significant change to approve, but not yet implement, Project No. 4-1382. The changes reflect an adjustment in the maximum capital expenditure to reflect increases in the gross square feet for new construction and renovation, also for asbestos abatement and for development of a new septic system. The holder states that at the time the application was filed, the extent to which the renovation and new construction was required was underestimated in the application. After the facility was acquired by a new owner, who is now requesting this change, they discovered that there were several areas in the facility that were undersized. There were also special deficiencies which they had to correct to meet statewide standards. They also discovered that during the renovation process, they discovered asbestos. That had to be removed. Originally, the former owner, had planned to develop a septic system outside the DoN process because the cost of it was less than the DoN threshold. However, during negotiations with the City, the owner discovered that the requirements imposed by the City for the septic system would increase costs beyond the DoN threshold. Now the owner is asking that this be included in this amendment. Staff finds that the costs are quite reasonable and consistent with the Public Health Council's decision and recommends approval on the basis that these changes could not have been foreseen when the application was originally filed."

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve the Request of Previously Approved DoN Project No. 4-1382 of Sharon Senior Care Center** to increase the gross square feet 24,655 (17,466 for renovation and 7, 189 for new construction including 4,568 for the 12 DoN-exempt beds), and the MCE to $2,461,979 (February 1999 dollars). This amendment is subject to the following condition:

All other conditions attached to the original and amended approval of this project shall remain in effect.

The MCE is itemized as follows:

| | |
|---|---|
| Construction Costs: | |
| Land Acquisition | $ 0 |
| Land Development | 27,000 |
| Construction Contract \ | |
| Fixed Equipment not in Contract > | 1,175,769 |
| Architectural & Engineering Costs / | |
| Site Survey and Soil Investigation / | |
| Major Movable Equipment | 200,117 |
| Pre-&Post-Filing Planning & Development | 83,044 |
| Other: Asbestos Abatement | 26,000 |
| Other: Septic System Replacement | 678,470 |
| Other: Gas Heating Conversion | 45,000 |
| Total Construction Costs | $2,335,400 |
| Financing Costs: | |
| Net Interest Expense | $ 71,404 |
| Costs of Securing Financing | 55,175 |
| Total Financing Costs | $ 126,579 |
| Total Maximum Capital Expenditure | $2,461,979 |

**CATEGORY 2 APPLICATIONS:**

**PROJECT APPLICATON NO. 1-3967 OF MERCY HOSPITAL, INC. TO ADD A 24 BED CHILD/ADOLESCENT PYSCHIATRIC UNIT AT ITS PROVIDENCE HOSPITAL CAMPUS:**

Ms. Holly Phelps, Consulting Analyst, Determination of Need Program, said in part, "…Mercy Hospital is proposing to establish a 24-bed child and adolescent psychiatric unit at its Providence Hospital Campus in Holyoke. 308 Exemptions have granted the establishment of the unit, and 12 beds are currently operational. Staff finds that the project meets all the requirements of the relevant guidelines. I projected year 2000 bed need and looked at available beds and found that there are no inpatient child psychiatric beds in the State of Massachusetts west of Natick. The Department of Mental Health and the Mass. Behavioral Health Partnership, which is the managed care entity that works with the Medicaid program on placing mentally ill Medicaid recipients, because of this situation which occurred with the closing of Charles River West and Baystate's units last year, organized an open planning process to address this problem. Mercy's proposal is a culmination of that process. The Department of Mental Health and the Behavioral Health Partnership are both in favor of the project. We have received letters of support from members of the Senate and the House of Representatives of the Hampshire, Hampden, and Franklin counties. Jay Breines, Executive Director of the Holyoke Health Center, formed a Ten Taxpayer Group and requested a public hearing at which representatives of Holyoke Health Center attacked Mercy Hospital and the Sisters of Providence Health Systems for their role in the healthcare environment in Holyoke, and, more specifically, disputes they were having with Mercy and Sisters of Providence. There were contractual disputes and otherwise…Responding to the hospital's alleged interference with Holyoke Health Center's obstetrical referrals, staff notes that in correspondence in November 20th between the boards, shows Sisters of Providence outlining a process for implementation of the non-solicitation clause of the management contract, which only requires Holyoke Health Center to document for the hospital a patient's desire to be served by an obstetrician not affiliated with the applicant, if a patient so chooses to receive care elsewhere, which is one of the complaints of the Ten Taxpayer. This project is not like the transfer of ownership projects involving the hospitals in the mergers where community groups are concerned about the consequences of the transfer of ownership for services that are going to be available to the community in the future, and very legitimately come before the Council with request for conditions to be added to approval of the transfer of ownership as an assurance that certain services are going to be available in the future. This is not that kind of project. This is a very specific project for a very specific service that is

universally recognized as very badly needed by the children in Western Massachusetts. Staff's position is that the Ten Taxpayers' issues are totally unrelated to the project beyond the purview of the DoN process, and that the proper forum for resolution of the contract disputes is the courts, and for resolution of other complaints are other Agencies of State Government. The rest of the individuals testifying at the hearing, including the Society for the Prevention of Cruelty to Children, the Alliance for the Mentally Ill, the Juvenile Court of Holyoke, and families with seriously mentally ill children talked about the catastrophic effects of having inadequate beds available for children, including the incarceration of violent children that the courts recognized should receive psychiatric placement, the placement of kids in Western Mass. as far away as Jamaica Plain, and what that does in terms of the kid being away from home, the availability of the family for the child, and discharge planning with local agencies, and worst of all, families who are unable to place their kids at all. Staff notes that written comments from an advocacy group for the mentally ill argue that it was unreasonable for the Ten Taxpayer group to delay action on such a much needed project based on unrelated issues. Staff is recommending approval of this project with staff's original conditions related to the maximum capital expenditure, the gross square footage, and the community health initiative listed."

Dr. Jonathan Chasen, C.E.O., Sisters of Providence Behavioral Healthcare, said in part, "…I am responsible for the behavioral health services offered at Providence Hospital in Holyoke and Bright Side in West Springfield. The families and the professional community in Western Massachusetts continue to experience extreme challenges and hardship in securing safe, clinically appropriate treatment for children and adolescents in need of acute psychiatric care…Providence Hospital currently runs a 12-bed inpatient child and adolescent unit and is seeking to expand to 24 beds. The unit at Providence is at its capacity almost continuously, making access for needed beds extremely difficult. These 12 beds are the only beds west of the Metropolitan Boston area specifically designated for children's psychiatric care. The Sisters of Providence have been carrying out their mission of being a healing presence in the communities that we serve, particularly for those that are most vulnerable. The investment of capital and human resources for this project provides further evidence of our commitment to this mission today. Our children are our future, and we must step forward to meet their needs, especially those with emotional and behavioral disorders. It is with this strong sense of commitment to our mission that I request approval for the expansion of child and adolescent beds. In order to meet the needs of the community, we are prepared to make a significant investment in the future of our children. In addition to expanding our capacity, the plans that we have submitted are also designed to alleviate several existing problems with our 12-bed unit by creating separate living areas for the younger children and the adolescents and creating a separate area for education. And overall renovation costs for child and adolescent beds. In order to meet the needs of the community, we are prepared to make a significant investment in the future of our children. Overall renovation costs for child and adolescent services of almost $1 million in renovations and equipment will be made to complete this project. As a regional center for children, it is important to do more than just expand the capacity; it is critical to correct previous problems and create a center of excellence…The need is compelling and the time to act is now…On behalf of all of the families and children who struggle with mental illness every day, thank you for your efforts to increase access to services in Western Massachusetts."

Mr. Jay Breines, Executive Director, Holyoke Health Center, Ten Taxpayer Group, said in part, "We do support the beds that are before you right now. Our concern was the relationship of the hospital within the community and how it impacts other parts of the public health system. I identified four conditions that we wanted to have attached to the approval of these beds. They were that Mercy Providence should cease interfering with the patient/provider relationships within the Holyoke Health Center; the Mercy Providence Hospital should expand its mental health services for Latinos; Mercy Providence should provide $300,000 per year for free mental health services for the uninsured; and Mercy Providence Hospital should cease its attempt to evict the Holyoke Health Center from its 317 Maple Street site…Another area of concern related to this DoN is the impact that the hospital action can have on mental health needs of our community. Our patients have very high rates of mental health problems, although most of them are not presenting problems when they show up for visits but they are part of the care system. We have found that 91 percent of our patients with mental health problems were not linked to mental health services. The care that they receive at the Holyoke Health Center is the only care that they are getting. If Mercy is allowed to evict us, the disruption that this will cause will include fewer visits for patients. This will have a negative impact on the

mental health status of these patients. As Mercy Providence files for increased mental health beds to support the large unmet need in our region, and as they propose to offer community screening support as a community benefit, they, at the same time, are placing low-income Latino patients at greater risk for mental health problems…The Holyoke Center is looking to the Public Health Council to improve the public health functioning within the Holyoke community. What the hospital wants to frame as a lease dispute is really a question of the misuse of power and position. This situation can be addressed by the Public Health Council if the four conditions we propose are attached to the approval of the psychiatric unit. By linking community-oriented behavior to the responsibilities of increasing the concentration of hospital beds within one institution, the message will be clear that the public health needs of a community cannot be ignored by institutions and they can be held accountable as their needs for project approvals materialize…We seek DoN support to both approve the new beds, as well as to prevent the hospital from disadvantaging the Latino population in Holyoke by disrupting its primary healthcare system that is developing…"

After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 1-3967 of Mercy Hospital, Inc., (summary of which is attached to and made a part of this record as Exhibit Number 14,654)**, based on staff findings with a maximum capital expenditure of $982,878 (January 1999 dollars) and first year incremental operating costs of $2,768,799 (January 1999 dollars). As approved, the application provides for the addition of a 24-bed child/adolescent secured psychiatric unit at its Providence Hospital campus. This Determination is subject to the following conditions:

1. The Applicant shall accept the approved maximum capital expenditure of $982,878 (January 1999 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 10l.751 and 752.

2. The gross square feet (GSF) for this project shall be 23,565 GSF for renovation of the existing space.

3. The Applicant shall provide $50,000 (January 1999 dollars) over a two year period ($25,000 annually) for staff time and administrative support to conduct and train other community organizations including school personnel to conduct substance abuse and mental health screenings in close coordination with the CHNA Central Office.

The Jay Breines Ten Taxpayer Group registered in connection with this project and requested a public hearing which was held on April 14, 1999 at Holyoke Community College.

**PROJECT APPLICATION NO. 4-3968 OF DANA-FARBER CANCER INSTITUTE TO PROVIDE POSITRON EMISSION TOMOGRAPHY SERVICES THROUGH ACQUISITION OF A PET SCANNER:**

Ms. Joan Gorga, Determination of Need analyst said, "The applicant, Dana-Farber Cancer Institute, is seeking approval to provide positron emission topography, or PET scanning, through the purchase of a PET scanner. The Dana Farber application was reviewed using the Determination of Need Guidelines for PET, which were approved in November of 1998. PET has been used as a research tool for over a decade, and differs from conventional imaging procedures because it allows for the quantitative assessment of functioning organ systems. Clinical applications of PET fall into four primary areas: cardiology; neurology; psychiatry; and oncology. Dana-Farber will be using PET for diagnosis and for disease staging in lung cancer patients and to diagnose recurrence in colorectal cancer patients. Dana-Farber met all of the standards and measures included in the guidelines. The combined market shares of Dana-Farber and the hospitals referring patients to the service were 1.6 million people as required by the guidelines. Dana-Farber's outpatient cancer patients alone will generate the required minimum demand of 1,250 cases per year. Dana-Farber will provide the required staff and develop a clinical oversight committee. Radiopharmaceuticals necessary for PET scanning at Dana-Farber will be produced at the MGH Cyclotron. Dana Farber has calculated that the service will break even each year, and staff has found that the cost of the scanner is compatible with citations in the literature included in the guidelines. Staff found that Dana-Farber met the requirements of the community health initiatives of the DoN regulations."

After consideration, upon motion made and duly seconded, it was voted: [Chairman Koh, Ms. Slemenda, Ms. Kearney Masaschi, Mr. Sneider, Mr. George Jr., Mr. Sherman; Dr. Askinazi and Dr. Sterne abstaining due to M.G.H. affiliation; Mr. Yaffe absent] **to approve Project Application No. 4-3968 of Dana-Farber Cancer Institute to provide Positron Emission Tomography services through acquisition of a PET scanner**, (summary of which is attached to and made a part of this record as **Exhibit Number 14,655)**, based on staff findings, with a maximum capital expenditure of $1,700,000 (January 1999 dollars), and first year incremental operating costs of $1,866,453 (January 1999 dollars). As approved, the application provides for establishment of Positron Emission Tomography (PET) services through acquisition of a PET body scanner and dedicated computers to be located in the Dana-Farber Radiology Department. This Determination is subject to the following conditions:

1. The Applicant shall accept the maximum capital expenditure of $1,700,000 (January 1999 dollars) as the final cost figure, except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. The Applicant shall contribute 100% equity to the final approved MCE.

3. The Applicant shall not consider ability to pay or insurance status in selecting or scheduling patients for PET services.

4. The Applicant shall have in place the following elements of a professional medical interpreter service:

    a. A paid, full time Coordinator of Interpreter Services

    b. Provision of an interpreter service by paid, well-trained interpreters who shall be available for non-English languages on an on call basis 24 hours per day for all outpatient services including laboratory and x-ray. The AT&T language line will be used.

    c. Periodic training for interpreters on medical terminology, particularly the high technology practiced at the Center, and for medical providers on working effectively with interpreters, and in clients' cultures and health belief systems;

    d. A system for monitoring the primary language of outpatients and periodically compiling those statistics for the purpose of evaluating the adequacy of the services.

    e. A system for tracking requests for interpreter services and the hospital's response to those requests.

    f. There shall be publicity regarding the availability of the service within the hospital and the community, and community input shall be sought for the development of the service.

    g. A plan for interpreter services shall be submitted prior to implementation to the Director of the DoN Program and the Director of Refugee and Immigrant Health within 180 days of DoN approval. Progress reports shall be submitted yearly on the anniversary date of the DoN approval.

5. The applicant will provide not less than $110,000 over a six-year period for statewide disease prevention programs in prostate and colorectal cancer which will focus on screening services for underserved, at-risk communities with additional support for the participation of community care practitioners in appropriate screening, diagnosis and therapeutic programs. Funding for these initiatives will begin upon project implementation. Prostate disease prevention funds will be distributed over six years.

The meeting adjourned at approximately 11:55 a.m.

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Dr. Howard K. Koh, Chairman
Public Health Council

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